



TRICARE Prime Remote Enrollment or Change Form

Check appropriate box for all that apply

- ☐ Enrollment
(Complete Active Duty Service Member Information Section & Signature Section)
- ☐ Address Change
(Complete #1-13 in ADSM Information Section & Signature Section)
Effective Date of Move _____
- ☐ Transfer / Portability
(Complete ADSM Information Section & Signature Section)

- ☐ Disenrollment
(Complete #1 & 2 of ADSM Information Section, Disenrollment Section & Signature Sections)
- ☐ Primary Care Manager Change
(Complete #1-9 in ADSM Information Section & Signature Section)

Reason for Change _____

Active Duty Service Member Information

1. ADSM Name			Last		First		MI		2. ADSM Social Security Number				
3. Birthdate		Mo.	Day	Yr.	4. Branch of Service		5. Rank		6. Pay Grade		7. Sex M / F		
8. ADSM'S 1st Choice of PCM (Refer to the TRICARE Provider Directory for Guidance)*													
9. ADSM'S 2nd Choice of PCM (2nd Choice Will Be Honored If Your 1st Choice is Full)													
10. Physical Home Address		Street		Apt. #		City		County		State		Zip Code	Phone ()
11. Physical Work Address		Street		Apt. #		City		County		State		Zip Code	Phone ()
12. Unit of Assignment Address		Street		Apt. #		City		County		State		Zip Code	Phone ()
13. Unit of Assignment													
14. ADSM Military ID Card Number					15. Date Military ID Card Issued				16. Military ID Card Expiration Date				
17. Have You Enclosed Your Completed Health Enrollment & Assessment Review (HEAR) Form?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													

Disenrollments

18. Check Reason for Disenrollment

☐ Moved to Non-remote location
Address _____

☐ Retired
Effective Date _____

☐ PCS Orders
Please Attach a Copy of Your PCS Orders.

☐ Separated From Armed Forces
Effective Date _____

☐ Other _____

Signature

19. Please review the Agency Disclosure and Privacy Statement on the Reverse Side Before Signing.

ADSM or Unit Commander signature

Date

When Complete, Enclose Enrollment and HEAR Form & Mail to:

Humana Military Healthcare Services, Inc.
P.O. Box 740072
Louisville, KY 40201-7472

Authority: 10 U.S.C. Chapter 55, CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime Program. Routine Uses: Verify eligibility and produce enrollment cards. Disclosure is voluntary. Failure to provide the information could result in denial of reimbursement under the CHAMPUS Program.

Please Return White Copy, Retain Yellow Copy For Your Records.